**Department of Case Management**

## Questions?

Your questions are important. Call your doctor or health care provider if you have questions or concerns. McLaren Flint staff are also available to help at any time.

For Case Management assistance please ask your nurse or health care provider for a referral. Or, you may call the Case Management Department at (810) 342-2375.


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## Answers to common questions.

Every patient at McLaren Flint will have a discharge plan. This is the term we use to speak about the end of your hospital stay and your care after you leave the hospital.

If your stay is scheduled ahead of time, the planning may start before you arrive. If your hospital stay is not planned ahead, the planning for your discharge will start soon after you arrive. This brochure explains your role in the process, and answers common questions about care transitions/discharge planning.

## How does discharge planning work at McLaren Flint

You and your family are our partners in planning a safe, smooth, and prompt discharge. Upon admission to the hospital, we work with you and your family to begin your discharge planning process. This is done by gathering information and resources so that we can review all of the options for what you will need after you leave the hospital.

- Every patient, patient representative and physician has the right to request a discharge planning evaluation.

## Who can help with discharge planning?

The professional staff from the Department of Case Management will collaborate with all of the disciplines who provided services or attention to you during your hospital stay to assist with a discharge that is both safe and meets your medical needs.

## How can I help with my discharge plan?

To help with your discharge plan:

- Ask your doctor how long you are expected to stay in the hospital, and what assistance he or she recommends.
- Tell your nurse the medications you already have at home, and where you plan to fill your prescriptions.
- Talk with your family and support system about how they are able to help at home upon discharge. Tell your nurse if you do not have someone who can help you at home.
- Ensure you and/or your representative has keys to your home/ car.



## Notes and important contact numbers:

## How will I pay for my after-care?

The Case Managers and Social Worker staff will assist you in obtaining authorization coverage for your discharge planning needs by working with your insurance provider to find out what services you qualify for and which services are covered. Some services that you may need at home may not be covered by your insurance plan. The Case Management and Social Work staff will help you sort this out, and let you know if there are other resources available to you.

The Case Management staff will work closely with your insurance company to ensure your medical needs will be addressed when you are preparing to discharge from the hospital – some examples of medical needs can include discharge medications, discharge to nursing or rehab facilities, and home health or medical equipment.

## We're here to help...

Just as every patient has a discharge plan, you also have a care plan for your hospital stay. Ask your nurse to review it with you so that you will know the goals for your stay.

Your nurse or Case Manager can answer any questions that you or your family may have. Or, they can help direct you to the person who will know the answer.



- Talk with your nurse about getting home. If there are restrictions on how you can travel, the nurse will help you make plans.
- In general, your discharge time is at 11:00 am (unless otherwise scheduled). Please confirm your discharge time with your nurse or doctor and arrange your ride in advance. We will make every effort to have everything ready for your planned discharge time.

## What do I need for my hospital stay that will help with planning for discharge?

- Health insurance card.
- Pharmacy or drug benefit card (this is part of many insurance cards)
- Legal papers about your health care, such as a Health Care Directive (Living Will) and Power of Attorney, if you have them.
- Phone numbers of family or friends you may want contacted during your stay.
- Glasses, hearing aids, dentures, or any other health aids that you may use.
- Current photo identification if traveling by plane.
- It is best to leave valuables at home.

## What if I need skilled nursing facility (SNF) services after discharge?

If you, or your care team, determine that you need the specialized services of a skilled nursing facility, a member of the Case Management Department will meet with you and your family to provide a list of facilities and ask you to decide on your top choices based upon bed availability. We will make every effort to arrange care in one of your preferred choices.

Your Case Management Team member will help coordinate all of your discharge processes.

The Social Worker will help to find a skilled nursing facility, and can provide you with information about legal and community resources. The Social Worker also provides emotional support to you and your family as needed.

Due to the demand for hospital services, we cannot allow you to stay once you no longer need to be in the hospital.

## What if I need rehabilitation services at discharge?

Rehabilitation can occur in an inpatient setting, a skilled nursing facility, or in the home, depending on your needs. Inpatient rehab admission is based on:

- Your diagnosis and condition;
- Your expected progress;
- Your insurance coverage;
- Bed availability.

Your doctor will order a rehab evaluation for in-hospital rehabilitation if needed.



## What if I need help at home?

Home health means the skilled services of a nurse or physical, occupational, or speech therapist and the service requires a doctor's order. Home health is often covered by insurance, and will be arranged by a Home Care Coordinator who will also verify your insurance and discuss the guidelines surrounding home care services.

Home care programs generally do not offer "skilled" services and are not covered by insurance. These programs may include help with:

- Transportation
- Bathing
- Dressing
- Feeding
- Housework
- Cooking

A member of the Case Management Team will provide you with a list of agencies so you and your family can arrange for help if you need it.